SERVICE COORDINATION ANNUAL ASSESSMENT

A. IDENTIFYING INFORMATION

Name: _____ SS#: _____ DOB: _____

Service Coordinator (SC): _____

Service Coordination Provider: _____

Assessment Completion Date: _____ Next Plan Due Date: _____

B. SOURCES OF INFORMATION

1. People Providing Input:

_____

Name Relationship/Agency Date

_____

Name Relationship/Agency Date

_____

Name Relationship/Agency Date

2. Records/Reports Used:

_____

Title of Report Submitting Party/Agency/Provider Date of Report

_____

Title of Report Submitting Party/Agency/Provider Date of Report

_____

Title of Report Submitting Party/Agency/Provider Date of Report

C. HEALTH

1. Physical:

a. Person has a Primary Care Physician: ☐ Yes ☐ No
b. Person has regular physician visits: ☐ Yes ☐ No

2. Dental:

a. Person has a Dentist: ☐ Yes ☐ No
b. Person has regular dental visits: ☐ Yes ☐ No
c. Concerns with teeth/gums/mouth/chewing: ☐ Yes ☐ No

3. Vision:

a. Concerns with vision: ☐ Yes ☐ No (If no, go to question 4)

Has this person's vision been evaluated by an Optometrist/Ophthalmologist? ☐ Yes ☐ No
If yes, were recommendations/orders followed? ☐ Yes ☐ No

If person wears glasses, list as an assistive device in chart (at question 7).

4. Hearing:

a. Concerns with hearing: ☐ Yes ☐ No (If no, go to question 5)

Has this person's hearing been evaluated by an Audiologist? ☐ Yes ☐ No
If yes, were recommendations/orders followed? ☐ Yes ☐ No

If person wears hearing aids, list as an assistive device in chart (at question 7).

5. Specialty:

a. Are other specialists seen regularly?: ☐ Yes ☐ No

If yes, list areas of specialty: _____ _____

_____ _____

6. Diet/Weight:

a. Person has a diet prescribed or recommended by a professional (i.e., doctor, dietician):
☐ Yes ☐No/Unknown
If yes, type: _____
If yes, is prescribed diet followed? ☐ Always ☐Most Times ☐Rarely/Never ☐ N/A

b. Weight Range:
☐ Under ideal weight range
☐ Within ideal weight range
☐ Over ideal weight range

7. Does this person have a/medical condition(s) for which an intervention (e.g., medication, supplies, equipment) are used prescribed? ☐ Yes ☐ No
If yes, list those currently prescribed/provided:

Condition	Medication/Intervention /Treatment/Supplies and Medical Equipment	Provider Type	Being taken /used/received As Prescribed? Yes or No	Current Funding Source	Is Medication/Intervention/ Treatment/Supplies and/or Medical Equipment effective in meeting the concern/condition for which it is given?
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No

8. Type of Disability: (Check all that apply)

☐ Intellectual Disability
☐ Related Disability (specify): _____
☐ Spinal Cord Injury (SCI) Level of SCI (specify): _____
☐ Traumatic Brain Injury
☐ Similar Disability (specify): _____
☐ Autism
☐ Pervasive Developmental Disorder
☐ Other (specify): _____

9. Tobacco usage: ☐ Yes ☐ No

10. Does the administration of this person's care, medications or medical treatments require specific training and/or the use of nursing judgement (injections, giving/withholding medications based on current condition wound care, equipment operation/cleaning, etc.)? ☐ Yes ☐ No

If yes, explain: _____

_____

11. Any concerns related to medical conditions, medications, treatments, devices, and/or supplies?
☐ Yes ☐ No If yes, list: _____

12. Receives/has received Genetic Services/Counseling: ☐ Yes ☐ No
If No, person is interested in receiving this: ☐ Yes ☐ No ☐ N/A

13. Is information needed about medical screenings or other health related guidelines: ☐ Yes ☐ No

Comments related to Health :

D. CURRENT RESOURCES

1. Current resources: (Please check all that apply):

☐ Earned Income ☐ SSDI ☐ SSI
☐ VA Pension ☐ Disability Insurance ☐ Worker's Compensation
☐ Food stamps ☐ Housing Supplement ☐ Child Support
☐ Trust/Settlement ☐ Health Insurance ☐ Alimony
☐ Medicaid ☐ Medicare: Part ☐ A; ☐ B; ☐ C; ☐ D
☐ Retirement/Pension ☐ PASS plan
☐ IRWE ☐ Life Insurance/Burial
☐ HCB Waiver (list which one): _____
☐ Family Support Funds ☐ Other: _____
☐ No resources

2. Do additional resources appear to be needed to meet basic needs such as sufficient food, adequate shelter, or life sustaining medications? ☐ Yes ☐ No

Comments related to Current Resources:

E. ACTIVITIES/SKILLS/ABILITIES

1. Daily Living	Degree/Level of Support/ Supervision/Assistance Needed to Complete				Expected or typical frequency of task/activity	Frequency Support is currently provided	Type of Support currently provided	Anticipated/expected ability of each supporter to Continue	Would Training/ Instruction/Intervention to increase skills be beneficial and desirable?
	None or equal to others of the same age- *if chosen, do not answer other parts of chart*	Prompts, reminders or supervision needed to complete or assure quality	Hands on, physical assistance needed with any portion of the task/activity	Completed by another	MD: Multiple times daily D: Daily MW: Multiple times weekly W: Weekly MM: Multiple times monthly M: Monthly O: Other frequency NE: not expected due to young age	1: Provided as needed 2: Provided some of the times needed, but not all 3: No support provided	N= Natural P= Paid X= None	1: Likely to continue without change 2: Change probable/likely within six months 3: Need for change evident/expressed or immediate (if more than one supporter, answer for each)	**Yes or No**
Prepare Meals									
Housekeeping									
Medical Care/ monitoring									
Shopping									
Personal Finan-cial Business									
Phone use									

Comments regarding Daily Living activities/skills/abilities:

2. Personal Care	Degree/Level of Supervision Needed to Complete				Expected or typical frequency of task/activity	Frequency Support is currently provided	Type of Support currently provided	Anticipated/expected ability of each supporter to Continue	Would Training/ Instruction/Intervention To increase skills be beneficial and desirable?
	None or equal to others of the same age - *if chosen, do not answer other parts of chart*	Prompts, reminders or limited supervis-ion needed to complete or assure quality	Hands on, physical assistance needed with any portion of the task/activity	Completed by another/ Constant Supervision	MD: Multiple times daily D: Daily W: Weekly O: Other frequency NE: not expected due to age	1: Provided as needed 2: Provided some of the times needed, but not all 3: No support provider	N: Natural P: Paid X: None	1: Likely to continue without change 2: Change probable/likely within six months 3: Need for change evident/expressed or immediate (if more than one supporter, answer for each)	**Yes or No**
Bathe/Shower									
Toilet or Incontinence care									
Dress/Groom									
Eating									
Take or apply Medicine(s)									
Transferring									
Supervise self (manages self, can be alone)									

Comments regarding Personal Care activities/skills/abilities:

3. Toilet Use (check all that apply):

☐ Independent ☐ commode ☐ bedpan ☐ urinal
☐ catheter ☐ ostomy ☐ bowel program ☐ diapers
☐ underpads ☐ independent with catheter/bowel care
☐ requires assistance with catheter/bowel care
☐ Other: ____

4. Mobility and Access

a. Person can get to all areas of their home:

☐ Without assistance
☐ With aid or equipment
☐ Must have personal assistance
☐ Cannot get to some or needed portions of home

b. Person has access to their possession (i.e., can use cabinets, storage areas, faucets, door knobs/handles):

☐ Without assistance
☐ With aid or equipment: Choose mode of Locomotion
☐ Must have personal assistance
☐ Cannot get to some or needed portions of home

c. Method of Mobility: *check all that apply*

☐ Walks without aid or assistance (if checked, skip to letter e/question e)
☐ Walks with aid or assistance (Type of aid: ☐ Cane ☐ Crutch ☐ Walker ☐ Other
☐ Uses a wheelchair without aid or assistance (*i.e., propels self*)
Type of chair used: ☐ Manual ☐ Power
Wheelchair is primary mode of locomotion? ☐Yes ☐ No
☐ Uses wheelchair with aid or assistance, (*i.e., other person wheels*)

d. Does this person use an aid or equipment for mobility and access? ☐ Yes ☐ No
If yes, list Aids/Equipment Used for Mobility an Access:

Type of Aid/Equipment	**Frequency Used**	**Condition of Aid/Equipment**	**Effectiveness of Aid/Equipment**
	☐ As ordered/needed ☐ Occasionally ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasionally ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasionally ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasionally ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasionally ☐Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need

e. Any injuries during the past year due to mobility issues (falls, equipment failure, etc.)?
☐ Yes ☐ No
If yes, describe each incident: ____

f. Any mobility issues related to exit during fire/emergency (include issues related to emergency evacuation of home during disaster)? ☐ Yes ☐ No
If yes, describe: ____

g. Would an evaluation of mobility or interventions to increase independence or slow down loss of mobility likely be beneficial and desirable? (e.g., physical therapy) ☐ Yes ☐ No

h. Is this person working with a professional to improve his/her mobility or to prevent regression?
☐ Yes ☐ No

Comments related to Mobility:

5. **Fine Motor**

a. Method used for performing fine motor tasks/grasping (holding utensils for dining, writing, tooth brushing, dressing, etc.): *check all that apply*

☐ Own hands without aid or assistance (If yes, skip to question c)
☐ Own hands with aid/equipment
☐ Performed by another

b. Does this person use aids/equipment to perform fine motor tasks? ☐ Yes ☐ No
If yes, list Aids/Equipment Used to perform fine motor tasks:

Type of Aid/Equipment Used	**Frequency or Use**	**Condition of Aid/Equipment**	**Effectiveness of Aid/Equipment**
	☐ As ordered/needed ☐ Occasional ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasional ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasional ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasional ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasional ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need

c. Any increased dependency noted in the past year with ability to perform fine motor tasks?
☐ Yes ☐ No
If yes, describe: _____

_____

d. Might an evaluation of fine motor skills or interventions to increase independence or slow down the loss of fine motor ability be beneficial and desirable? (e.g. occupational therapy).
☐ Yes ☐ No

e. Is this person working with a professional to improve fine motor ability or to prevent loss of fine motor ability? ☐ Yes ☐ No

Comments related to Fine Motor:

6. Communication

a. **Communication is easily understood by**:

Primary/experienced caregivers? ☐ Yes ☐ No
Those with whom interactions occur regularly? ☐ Yes ☐ No
Others with whom he/she lives and/or works? ☐ Yes ☐ No
Strangers? ☐ Yes ☐ No

b. Does this person use devices/equipment to aid with communication? ☐ Yes ☐ No
If yes, list devices/equipment used for communication:

Type of Device/Equipment Used	Frequency or Use	Condition of Device/Equipment	Effectiveness of Device/Equipment
	☐ As ordered/needed ☐ Occasional ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasional ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works ☐ Meets portion of need ☐ Does not meet the need

c. Primary methods/s of communication: (check all that apply)

☐ Verbal (with words)
☐ Oral (sounds but not discernable words)
☐ Physical responses/gestures (pointing, smiling, nodding; should also consider hitting, biting or other responses that would be considered "inappropriate or maladaptive")
☐ With equipment or device/s
☐ Other: _____

d. Were there significant changes noted in communication ability during the past year?
☐ Yes ☐ No
If yes, please explain changes: _____

e. If communication is not easily understood by all or if significant changes have occurred, would an evaluation or interventions to improve the likelihood of others understanding be beneficial and desirable (e.g., speech therapy)? ☐ Yes ☐ No ☐ N/A - is easily understood?

f. Is this person working with a professional to improve his/her communication ability?
☐ Yes ☐ No

Comments related to Communication:

7. Basic Transportation

a. Basic transportation (to/from work or school, to/from medical appointments, and to/from stores to obtain food and medicine) is available:

☐ At all times, as needed
☐ Sometimes
☐ Rarely or never

b. Does this person:

☐ Transport him\herself without assistance
☐ Make arrangements, but must be transported by another:
Explain: _____

☐ Rely on others

c. Has the most common vehicle used for transportation been adapted in order for this person to be transported? ☐ Yes ☐ No ☐ N/A
If yes, list adaptations:

Type of Adaptation	**Condition/Quality of Equipment/Adaptation**	**Effectiveness of Equipment/Adaptation**
	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need

d. Is there a need for an adapted vehicle? ☐ Yes ☐ No ☐ N/A
If yes, describe why adaptations are needed: _____

Comments related to Basic Transportation:

F. EMOTIONAL, MENTAL AND BEHAVIORAL HEALTH

1. Concerns with emotional/mental health: ☐ Yes ☐ No (If no, skip to next domain.)
If yes, please explain: _____

2 Behaviors that are concerning:

☐ Verbal aggression ☐ Physical aggression
☐ Sexual aggression ☐ Stealing
☐ Inappropriate sexual comments, gestures or touch ☐ Substance abuse
☐ Property destruction/damage ☐ Self-injury
☐ Pica ☐ Suicidal threats/attempts
☐ Withdrawn ☐ Wandering off/run-away
☐ Defiance ☐ Criminal/Illegal Activity (ies)
☐ Other: _____

Comments (include specifics regarding any criminal/illegal activity/ies):

3. Do concerns with emotional/mental health or behaviors affect the following areas:

Ability to function independently: ☐ Yes ☐ No
Ability to have positive relationships: ☐ Yes ☐ No
Ability to participate in desired activities: ☐ Yes ☐ No
Ability to attend school or be in a regular classroom: ☐ Yes ☐ No ☐ N/A
Ability to gain or maintain employment: ☐ Yes ☐ No ☐ N/A

4. Are services/supports being provided/prescribed to address emotional/mental health or behavior concerns? ☐ Yes ☐ No ☐ N/A
If yes, please list in the chart below:

Services/Supports	Provider type	Frequency	Funding Source	Is the service/support effective in addressing the concern for which it is provided?	Is the person/guardian satisfied with the service/support?
1.				☐ Yes ☐ No	☐ Yes ☐ No
2.				☐ Yes ☐ No	☐ Yes ☐ No
3.				☐ Yes ☐ No	☐ Yes ☐ No

Comments regarding Emotional, Mental, and Behavioral Health:

G. EDUCATIONAL OPPORTUNITIES

1. If not attending an educational program:

a. Person is interested in school or Adult Education Program: ☐ Yes ☐ No ☐ N/A
(If no, skip to next section.). If yes, explain why they are not attending: _____

_____

If yes, what are this person's educational interests: _____

_____

2. If attending an educational program:

a. Does the person attend: ☐ Public School ☐ College/University ☐ Technical College
☐ Trade/Vocational School ☐ Adult Education
☐ Other: _____

b. Are there any concerns related to the person's educational program? ☐ Yes ☐ No
If yes, please explain: _____

_____

Comments regarding Educational Opportunities :

H. VOCATIONAL

The person: ☐ works in a competitive job in the community ☐ works in a sheltered work setting
☐ works in an enclave or mobile work crew ☐ does not work (skip to question 2)
☐ is a child under working age? (If checked, go to section I.)

1. If working - Employer: _____

a. Are there services/supports provided to enable the person to work? ☐ Yes ☐ No
If yes, please list in the chart below:

Services/Supports	Provider Type	Frequency Service is Provided	Current Funding Source	Are services/supports being received effective in addressing the need?		Is the person satisfied with the services/supports?	
1.				☐ Yes	☐ No	☐ Yes	☐ No
2.				☐ Yes	☐ No	☐ Yes	☐ No
3.				☐ Yes	☐ No	☐ Yes	☐ No

b. Concerns regarding employment or employment related services/supports: ☐ Yes ☐ No
If yes, explain: _____

2. If not working:

a. Has this person ever been previously employed? ☐ Yes ☐ No
If yes, explain why he/she is no longer employed? _____
_____

b. In what kind(s) of work is this person most interested? (List interests): _____
_____

☐ Does not want to work (skip to section I if the person does not want to work)

3. Work Skills/Abilities: (answer if working or if not working)

a. Can the person: Yes No

☐ ☐ Follow/abide by general workplace rules
☐ ☐ Engage in task until completed or acceptable stopping period
☐ ☐ Work safely
☐ ☐ Report to work on time as expected
☐ ☐ Complete familiar or known tasks at an acceptable production speed or rate

b. Person has pursued services through SC Vocational Rehabilitation: ☐ Yes ☐ No
If yes, what was the outcome? Please explain: _____
_____

c. Does this person need 1:1 instruction and on the job training to learn job tasks? ☐ Yes ☐ No

d. Does this person need assistance to solve work related problems and/or understand work related issues? ☐ Yes ☐ No

e. Does this person have a picture identification card? ☐ Yes ☐ No

f. Does this person have a Social Security card? ☐ Yes ☐ No

Comments regarding Vocational:

I. LIVING ENVIRONMENT

1. Independent Setting:

a. This Person lives in an independent setting: ☐ Yes ☐ No
If no, skip to "Supervised/Supported Setting" section.
If yes, specify type: ☐ Alone in own home/apartment ☐ With Spouse/Children
☐ With Roommate/Housemate ☐ With Parents/Family
If living with others, with whom does he/she live?(please list)

Relationship	Age	Is this person a:
		☐ Primary Caregiver ☐ Secondary Caregiver ☐ Does not provide care
		☐ Primary Caregiver ☐ Secondary Caregiver ☐ Does not provide care
		☐ Primary Caregiver ☐ Secondary Caregiver ☐ Does not provide care

b. Does this person seem to feel safe and be well in this setting? ☐ Yes ☐ No

c. Does this setting appear to have any obvious hazards that could jeopardize this person's health/safety? ☐ Yes ☐ No

d. Does this person appear to be satisfied with this setting? ☐ Yes ☐ No

e. Do others in the home appear to be satisfied/supportive of the living arrangements?
☐ Yes ☐ No ☐ N/A (Lives alone.)

f. Is there a plan for where this person will live if current living arrangements cannot continue?
☐ Yes ☐ No
If yes, explain: _____

g. Does the primary caregiver have the opportunity for rest/relief from care giving responsibilities?
☐ Yes ☐ No ☐ N/A (Care is not provided or is not desired)
If yes, does the amount of rest/relief appear to be enough? ☐ Yes ☐ No
Is the primary caregiver satisfied with the amount of rest/relief (respite)? ☐ Yes ☐ No

h. Is there a plan for how care will be provided if the primary caregiver is unexpectedly unable to provide care? ☐ Yes ☐ No ☐ N/A (care is not provided)
If yes, please explain: _____

_____

i. Is there a plan for how supports/care will be provided when the primary caregiver can no longer provide care? ☐ Yes ☐ No ☐ N/A (no care provided)
If yes, explain: _____

_____

j. Is there a plan for what to do in the event of specific types of emergencies/natural disasters that would require displacement from this home? ☐ Yes ☐ No
If yes, does the emergency/disaster plan seem sufficient to assure the person will likely be safe and well (as healthy as possible) while evacuated? ☐ Yes ☐ No

k. Does the person/family need more information on what to do in the event of specific types of emergencies/ natural disasters? ☐ Yes ☐ No

2. Does the person/family need information on emergency shelters and/or transportation options in the event of an emergency/natural disaster? ☐ Yes ☐ No

3. **<u>Supervised/Supported Setting:</u>**

a. This person lives in a supervised/supported setting: ☐ Yes ☐ No (If no, skip to next section.)
If yes, specify type: ☐ CTH-I ☐ CTH-II ☐ SLP-I ☐ SLP-II
☐ DSN operated CRCF ☐ Nursing Facility
☐ CRCF/ Private Boarding Home ☐ Assisted Living Facility
☐ Other: _____
Name of company/Residential Provider/Agency/Facility: _____

b. Is the supervision/support provided effective in addressing needs? ☐ Yes ☐ No

c. Does the person seem to be satisfied with the setting in which he/she lives? ☐ Yes ☐ No

d. Does this setting appear to have any obvious hazards that could jeopardize this person's health/safety? ☐ Yes ☐ No

e. Does the person seem safe in this setting? ☐ Yes ☐ No

f. Does the person seem to be satisfied with the company/agency providing the supervision/supports and the setting? ☐ Yes ☐ No

g. Is there a plan for how emergencies/natural disasters requiring evacuation will be handled? ☐ Yes ☐ No
If yes, does the emergency/natural disaster plan appear to be sufficient to assure that he/she will likely be safe and well? ☐ Yes ☐ No

h. Is this person aware of other options/settings that may be available to him/her? ☐ Yes ☐ No

i. Is this person aware of the other providers that are available? ☐ Yes ☐ No

Observations/Comments (re: Living Environment):

J. COMMUNITY CONNECTIONS

1 Is this person present in his/her community? ☐ Yes ☐ No
If yes, how often? ☐ Often/Always ☐ Sometimes ☐ Rarely

2. Does this person participate in his/her community? ☐ Yes ☐ No
If yes, how often? ☐ Often/Always ☐ Sometimes ☐ Rarely

3. Does this person fulfill any social roles in his/her community? ☐ Yes ☐ No
If yes, which roles?: _____

4. Does this person seem satisfied with his/her current connection to the community? ☐ Yes ☐ No

Comments regarding Community Connections:

K. NATURAL SUPPORT NETWORK:

1. Is this person in touch with family members? ☐ Yes ☐ No
If yes, what methods are used (check all that apply)**:**
☐ visits/in person ☐ by phone ☐ through correspondence

2. Does this person appear to be satisfied with the amount of family contact? ☐ Yes ☐ No

3. Is this person in touch with friends (people who are not related and are not paid staff)? ☐ Yes ☐ No
If yes, what methods are used for contact (check all that apply):
☐ visits/in person ☐ by phone ☐ through correspondence

4. If living in a supervised/supported setting, does this person have someone who is not affiliated with the residential provider who visits him/her?

a) at his/her home? ☐ Yes ☐ No ☐ N/A
If yes, what is the visitor's relationship to this person?: _____

b) away from his/her home? ☐ Yes ☐ No ☐ N/A
If yes, what is the visitor's relationship to this person?: _____

_____

5. Does this person appear to be satisfied with the amount of contact with friends? ☐ Yes ☐ No

6. Does this person have relationships that are comfortable, familiar, and/or dear to them? ☐ Yes ☐ No

Comments regarding Natural Support Network:

L. SELF-ADVOCACY AND RIGHTS:

1. Does this person express personal preferences and interests? (including preferences regarding recreational/leisure activities)? ☐ Yes ☐ No
If yes, list examples of his/her preferences in the "Comments" box at the end of this section.
If no, explain: _____

_____

2. Does this person make choices? ☐ Yes ☐ No

3. Does this person demonstrate basic problem-solving skills? ☐ Yes ☐ No

4. Does this person "speak up" for him/herself when needed? ☐ Yes ☐ No

5. Does this person participate in a local self-advocacy group? ☐ Yes ☐ No
If no, would they like to? ☐ Yes ☐ No

6. Does this person know and understand his/her human rights? ☐ Yes ☐ No

7. Does this person know and understand his/her civil rights? ☐ Yes ☐ No

8. Does this person exercise his/her rights? ☐ Yes ☐ No

9. Person is registered to vote? ☐ Yes ☐ No
If no, person would like assistance to register to vote? ☐ Yes ☐ No

10. Does this person feel that he/she is treated fairly? ☐ Yes ☐ No
If no, explain: _____

_____

11. Does this person's rights appear to be restricted? ☐ Yes ☐ No
If yes, has he/she been afforded due process? ☐ Yes ☐ No ☐ N/A

Comments regarding Self-Advocacy and Rights:

M. PERSONAL PRIORITIES:

1. Has this person chosen personal goals for his/her life? ☐ Yes ☐ No
If no, would he/she like assistance in doing so? ☐ Yes ☐ No
If yes and he/she wishes to share, what are his/her goals?: _____

2. Does this person express a need for assistance to achieve his/her personal goals? ☐ Yes ☐ No
If yes, please explain: _____

Comments regarding Personal Priorities:

ASSESSMENT SUMMARY and PLANNING DOCUMENT

Needs Identified
Need: Will this need be included in this year's Support Plan? ☐ Yes ☐ No **If No, please explain why:**
Need: Will this need be included in this year's Support Plan? ☐ Yes ☐ No **If No, please explain why:**
Need: Will this need be included in this year's Support Plan? ☐ Yes ☐ No **If No, please explain why not:**
Need: Will this need be included in this year's Support Plan? ☐ Yes ☐ No **If No, please explain why not:**

Need:

Will this need be included in this year's Support Plan? ☐ Yes ☐ No

If No, please explain why:

Need:

Will this need be included in this year's Support Plan? ☐ Yes ☐ No

If No, please explain why:

Need:

Will this need be included in this year's Support Plan? ☐ Yes ☐ No

If No, please explain why not:

Need:

Will this need be included in this year's Support Plan? ☐ Yes ☐ No

If No, please explain why not: